IMED, INC.

2150 S. Central Expressway* Suite 200-262 * McKinney, TX 75070
Office: 469-219-3355 * Fax: 469-219-3350 * email: imeddallas@msn.com

10/28/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Right knee diagnostic arthroscopy, open medial plication, latter release

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a female with complaints of an injury to her right knee. On xxxx, she was taken surgery for right knee anterior cruciate ligament reconstructions with Achilles allograft. On xxx, the patient was taken back to surgery for right knee arthroscopy with lysis of adhesions in a suprapatellar pouch and anterior cruciate ligament. A right knee arthroscopy with anterior interval release was performed. On xxxx, the patient was taken back to surgery for right knee arthroscopy with latter release and debridement. On xxxx, x-rays of the right knee revealed the patient to be status post ACL reconstruction, with mild patellofemoral osteoarthritis and knee effusion. On xxxxx, a MR arthrogram of the right knee was obtained, noting the prior ACL repair without evidence of complication. The exam was limited by artifact. There was a small popliteal cyst and there was no acute abnormality identified; there was no significant arthropathy. The articular cartilage was preserved within the medial and lateral femoral tibial compartments as well as the patellofemoral compartment. The quadriceps and patellar tendons were intact and unremarkable. On xxxxx, the patient was seen in clinic. She had complaints of right knee pain status post three surgeries including ACL replacement and latter release with continued right knee pain. It was noted she had a current diagnosis of right knee instability and patellar subluxation. Objectively she had a limping gait, with medial and lateral joint line pain. She had a good endpoint to her anterior drawer, with a negative McMurray's and patellar crepitus. Range of motion was 0-110 degrees. Varus and valgus stress

testing was stable. Patellar subluxation was noted.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

On xxxx, a notification of adverse determination was submitted for the requested right knee diagnostic arthroscopy, open medial plication and lateral release. It was noted that Official Disability Guidelines did not address the Fulkerson procedure and Wheeless' Textbook of Orthopedics was utilized. It was noted that there was a large gap in treatment, with no documentation submitted to show evidence of treatment between xxxx and the clinical date xxxx. It was noted the documentation did not show evidence of failure of recent conservative care, and there was lack of evidence of subluxation. A peer to peer discussion occurred, and there was no significant additional information available to support the request at that time therefore the request was non-certified.

On xxxx, a notification of reconsideration determination was submitted for the requested appeal for the right knee diagnostic arthroscopy, open medial plication and latter release. That report utilized Official Disability Guidelines for diagnostic arthroscopy, as well as a peer reviewed article for lateral release. It was noted that exhaustion of failure of conservative care with recent physical therapy was still not documented, and imaging studies documenting an abnormal patellar tilt were not provided. It was noted that the request included CPT code 27429, ligamentous reconstruction which was not appropriate code. Therefore in the agreement with previous determination, the request was non-certified.

For this review, CPT codes were not provided. The request is for right knee diagnostic arthroscopy with open medial plication. The submitted records include a 05/13/15 progress note indicating the patient had complaints of right knee pain status post 3 surgeries, including a lateral release. It was noted that on exam, there was patellar subluxation and a positive apprehension test. The MR arthrogram dated xxxx found the prior ACL repair without evidence of complication, and a small popliteal cyst was noted. No other abnormalities were identified. Official Disability Guidelines indicates that indications for diagnostic arthroscopy would include documentation of conservative care including medications or physical therapy, plus pain and function limitations continuing despite conservative care plus inconclusive imaging. Recent attempts at conservative care need to be clarified, and the imaging is not inconclusive.

In a report, the authors stated "Standard patellofemoral exam should be performed including assessment of patella glide, crepitus, lateral apprehension, tracking, and alignment. Medial patella translation greater than 2 quadrants indicates loss of lateral patellofemoral restraints or underlying hyperlaxity7. Although increased laxity suggests the diagnosis, the key is to reproduce the patient's symptoms or apprehension with the medial patella subluxation test8. With the knee in full extension, the examiner applies a medial translational force to the patella. The knee is then flexed. In the first 30 degrees of knee flexion, pain, instability or dramatic reproduction of the patient's symptoms occurs as the patella snaps laterally into the trochlear groove… Physical therapy, specifically vastus lateralis strengthening, or the use of a patellofemoral brace during activities can be tried. Unfortunately, nonoperative management is often unsuccessful. Patients with continued symptoms after xxxxx of non-operative treatment can be indicated for surgical intervention."

In a study by Monk, et al, the authors stated "Patella subluxation assessed on dynamic MRI

has previously been shown to be associated with anterior knee pain. In this MRI study of 60 patients we investigated the relationship between subluxation and multiple bony, cartilaginous and soft-tissue factors that might predispose to subluxation using discriminant function analysis."

For this review, while the provider states the patella subluxes, there is no indication of an abnormal imaging in regards to patella tilt or subluxation. The Q angle has not been documented, as an abnormal Q angle, especially in a female, may indicate pre-disposition to recurrent patella subluxation. As stated, recent attempts at conservative care need to be clarified.

It is the opinion of this reviewer the quest for right knee diagnostic arthroscopy, open medial plication is not medically necessary and prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☒ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

McCarthy, Mark A., and Mathew J. Bollier. "Medial Patella Subluxation: Diagnosis and Treatment." *The Iowa orthopaedic journal* 35 (2015): 26.

"Standard patellofemoral exam should be performed including assessment of patella glide, crepitus, lateral apprehension, tracking, and alignment. Medial patella translation greater than 2 quadrants indicates loss of lateral patellofemoral restraints or underlying hyperlaxity7. Although increased laxity suggests the diagnosis, the key is to reproduce the patient's symptoms or apprehension with the medial patella subluxation test8. With the knee in full extension, the examiner applies a medial translational force to the patella. The knee is then flexed. In the first 30 degrees of knee flexion, pain, instability or dramatic reproduction of the patient's symptoms occurs as the patella snaps laterally into the trochlear groove… Physical therapy, specifically vastus lateralis strengthening, or the use of a patellofemoral brace during activities can be tried. Unfortunately, nonoperative management is often unsuccessful. Patients with continued symptoms after 3–6 months of non-operative treatment can be indicated for surgical intervention."

Monk, A. P., et al. "The patho-anatomy of patellofemoral subluxation." Journal of Bone & Joint Surgery, British Volume 93.10 (2011): 1341-1347.
"Patella subluxation assessed on dynamic MRI has previously been shown to be associated with anterior knee pain. In this MRI study of 60 patients we investigated the relationship between subluxation and multiple bony, cartilaginous and soft-tissue factors that might predispose to subluxation using discriminant function analysis."